Professional Liability Reform

Large jury awards, large settlements, and other financial losses to medical malpractice insurance companies have historically triggered rapid increases in the costs of liability insurance premiums. Malpractice insurance rates do have an impact on rural communities. High malpractice insurance premiums may add to health care access issues in these communities by forcing providers to eliminate high-risk services such as obstetrics and certain surgeries. Patients who need such services are forced to travel further for their care or are transferred to a facility that provides the necessary services. Additionally, high premiums can create difficulties for rural areas in recruiting or retaining an adequate number and mix of physicians, especially in certain high premium specialties. To decrease medical liability costs rural health care providers may choose to avoid high risk procedures, and consider consulting specialists in professional liability for help lowering malpractice insurance costs.

The federal government provides a way for certain rural health centers to lower their malpractice insurance costs through the Federal Tort Claims Act. The FTCA law allows for civil law suits to be brought against the United States for the negligent acts of its agents. Because the United States enjoys sovereign immunity, it cannot be sued unless a federal law waives such immunity. The FTCA does exactly that and allows for certain claims to be brought against the American government. Under the FTCA, a patient who is injured as a result of negligence by a federal employee at a U.S. government health facility (including the VA and Indian Health Services) may have the right to bring a claim under the FTCA.

The FTCA affects rural health through the creation of a medical malpractice insurance program for Federally Qualified Health Centers (FQHCs) that offers comprehensive medical malpractice protection for the centers at no cost to grantees who participate. What this means is that the FQHC officers and staff that are funded under section 330 can apply to be considered general employees for the purpose of medical malpractice and thus enjoy the same immunity from lawsuit as other federal employees do under the FTCA. By reducing the need for FQHCs to purchase private medical malpractice insurance, more funds are made available for clinical services. The Affordable Care Act (ACA) expands the FTCA protections to FQHC's nonmedical personnel (section 10608). The ACA also authorizes malpractice demonstrations by the states (section 10607).

Indeed, the fact that the ACA does little to change the medical tort reform system can be demonstrated in the small financial impact such reform would have on national health care spending in the United States. Tort reform has historically been brought up as a way to lower the large amount of money spent on health care in the United States. Unfortunately, there is little evidence that such reform would help control rising health care costs. Health Affairs reported that a 10 percent decline in medical malpractice premiums would result in less than one percent

savings in the total medical care costs in every specialty. Medical malpractice premiums account for less than two percent of total estimated national health spending.

In fact, with tort reform, national medical spending is projected by the Congressional Budget Office to only be reduced by 0.3 percent. "Even if medical malpractice premiums were to be reduced as much as 30 percent, defensive medicine costs would decline no more than 0.4 percent." However, the same Health Affairs Study found that though defensive medicine practice's impact on medical care costs is small, the practice itself is widespread. However, even though the medical liability system's financial impact on overall health care spending is by percentage small, the amount of money spent on the system in America is estimated to be higher than $55 billion annually.

The burden of malpractice risk is not evenly distributed amongst all specialties. A study published in the New England Journal of Medicine showed that malpractice risk did change according to a physician's specialty and that the vast majority of physicians would be faced with a malpractice claim in their career. However, though many, many physicians will be faced with a malpractice claim, only a small percentage of them end up making an indemnity payment. In each year of the study period, 7.4 percent of all physicians had a malpractice claim, but only 1.6 percent had a claim turn into a payment (this means that 78 percent of all claims did not result in payments to claimants).

Specialties in which physicians were most likely to face claims were not necessarily the specialties in which indemnity claims were most common. For example, gynecology had the twelfth highest annual proportion of physicians facing a claim, but had the highest payment rate. Indeed, the rates of overall claims and paid claims were the same regardless of physician age, year, or state of practice. By age 65, 99 percent of physicians in high-risk specialties (the five specialties with the highest proportions of physicians in a claim in a year, including neurosurgery, thoracic-cardiovascular surgery, general surgery, orthopedic surgery, and plastic surgery) were projected to face a claim and 71 percent were expected to make their first indemnity payment. In obstetrics and gynecology alone, 74 percent of physicians were projected to face a claim by age 45.

However, the medical liability system will also undergo changes with the emergence of new technologies, including Electronic Health Records (EHRs). The Centers for Medicare and Medicaid Services describe EHRs as being "an electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports." EHRs automate access to patient information and have the ability to support other care-related activities, including evidence-based decision support, outcomes reporting, and quality management.

EHRs' liability implications will likely vary over time as the systems are adopted. Initially, it is likely that implementation problems and adjustments may increase providers' liability risk. After the initial transition period, EHRs could reduce injuries (and thereby malpractice claims), but

may also change the way that malpractice cases are litigated. Additionally, assuming that EHRs become commonplace in provider workplaces, the legal standard of care may shift.

When EHRs are initially implemented, mistakes may occur as providers transition into using these new systems. Specialized training in EHR systems may help minimize the incidence of medical errors, as would tailoring the systems to existing technologies. Indeed, one legal case has suggested that providers may have a duty to minimize medical error risks during the EHR transition period (see Smith v. United States, 119 F. Supp. 2d 561 (D.S.C. 2000)). EHRs show some promise in preventing medical errors by decreasing transcription errors, improving communications among providers, and limiting the duplication of tests. However, despite all this promise, there is currently no evidence of EHRs actually reducing diagnostic errors. Additionally, the EHR system itself could be prone to errors should it have a faulty design. For example, there could be unaddressed differences between systems that could cause a myriad of problems such as medication dosage issues or cancellations. Also, due to the copy and paste functionality of EHRs, it is possible that providers could over rely on this utility and perpetuate earlier errors.

In addition to altering the risk of a malpractice claim against a provider, EHRs may also change how these claims are litigated by creating a new source of documentation to draw upon with which to prove or defend against a lawsuit. Such EHR documentation could make it easier for a provider to defend against a claim, but could also work against him/her should the record have been modified in an inappropriate way. As mentioned above, should EHRs truly become widespread, the standard of care may shift and a failure to adopt an EHR system could represent a deviation from it.

A review of the literature indicates that the malpractice crisis of the early 2000s seems to have lessened. Medical malpractice payout rates have been steadily decreasing since 2003 and have remained stable for the past few years. However, the medical malpractice crisis remains a focus for many professional organizations. The checks and balances provided by medical liability, regardless of its financial impact, or lack thereof, on national health care spending, remains an important component of the patient – doctor/provider relationships.

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